Inpatient Facility Payment Policy

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Public Plans contracting facilities that render inpatient services. For information on Commercial or Senior Products, refer to their respective inpatient facility payment policies.

This payment policy is intended to outline payment policies and procedures for inpatient admissions to acute medical facilities. Refer to the following policies for information on additional places of service and/or specific admission types: emergency department services, obstetrical and newborn admissions, observation services, skilled nursing facilities (SNF), acute rehabilitation admissions, or inpatient behavioral health facilities.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary inpatient services, in accordance with the member's benefits.

DEFINITIONS

Diagnosis Related Group (DRG) is defined by CMS as a patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. Tufts Health Plan incorporates the DRG methodology outlined in the provider agreement when processing inpatient claims. Tufts Health Plan determines the compensation rate for the inpatient hospital claim based on the DRG assigned according to the methodology, regardless of the DRG submitted on the claim.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Eligibility may be subject to retroactive reporting of disenrollment.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRALS/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

As a condition of payment, Tufts Health Plan requires inpatient notification for any member who is being admitted for inpatient care, regardless of whether primary or secondary coverage is with Tufts Health Plan. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the admitting provider. It is the submitting provider's responsibility to verify and confirm individual inpatient notifications.

Note: An inpatient notification does not take the place of a referral or prior authorization requirements for a service. For a comprehensive list of services that require prior authorization, refer to the Medical Necessity Guidelines section of the Resource Center.

Admitting practitioners and facilities are responsible for notifying Tufts Health Plan following the procedures outlined in the Referrals, Authorizations and Notifications chapter of the Tufts Health Public Plans Provider Manual and in accordance with the following time frames:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergency admissions must be reported within one business day of the admission
- Observation (and ED) services that result in inpatient an admission must be reported within one business day after the admission

Refer to the Compensation/Reimbursement Information below for additional information on late notifications.

Providers should log on the MHK portal through Tufts Health Plan's secure Provider portal to view real time status of the notification event and status of the event by following the directions provided.

Initial Determination for Coverage
Unless otherwise specified, initial determination for inpatient coverage is based on InterQual® criteria. Additional clinical information may be requested to support care management and transition of care needs. Tufts Health Plan's determination depends on the completeness and accuracy of the information submitted by the provider at the time of notification. Once the determination has been made, an approval and/or denial letter will be sent via fax.

Joint Surgery Program
Providers must request prior authorization for members for hip, knee and/or shoulder surgery through the National Imaging Associates' (NIA). Tufts Health Plan inpatient admission notification requirements for the facility or hospital admission must be obtained separately and only initiated after the surgery has met NIA's medical necessity criteria. Refer to the Joint Surgery Program page for additional information.

Discharge
The discharge date and inpatient notification number are conditions of payment. The discharge date must be reported as soon as possible.

READMISSION

Providers are prohibited from balance billing members. If a member must be readmitted and payment is denied, the provider is responsible for any associated costs. The following readmissions policies apply to DRG and/or case rate facilities.

Note: Subsequent admissions are considered a new admission for non-DRG or case rate facilities.

Payment for a readmission to the same acute facility within 30 days may be denied if Tufts Health Plan determines that the (re-) admission was due to a premature discharge or related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission. If the second admission is determined to be a readmission, the higher DRG of the two admissions will be compensated.

Effective for DOS on or after September 1, 2023, case rates are also subject to this time frame for Tufts Health Direct, Tufts Health Together, and Tufts Health RITogether members.

Note: This change only applies to acute medical readmissions.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable
- Interim billing is not allowed for acute medical admissions
- Late charges for Tufts Health Public Plans claims should be submitted using Bill Type 117 as a corrected claim and must include both the original charges as well as any additional charges

Same-Day Transfers
Tufts Health Unify

Include condition code 40 on the claim if the member is transferred to another facility before midnight on the same day as the initial admission, in accordance with CMS requirements.

Administratively Necessary Days (AND)
Providers must submit revenue code 0169 (Room & Board, Other) to report AND services.

Behavioral Health Services Provided within Acute Care Hospitals for Emergency Psychiatric Inpatient Admission (EPIA) Patients ("BH Boarding")
Tufts Health Direct
Effective for dates of service on or after November 1, 2022, acute care hospitals should bill using the following information for members receiving appropriate behavioral health (BH) care to treat and/or stabilize their condition while awaiting appropriate inpatient psychiatric placement. Providers should submit one claim for medical services and another claim for BH boarding services, as follows:

Medical Claim
- Submit Bill Type 11X
- Submit standard Room & Board revenue code; CPT/HCPCS code **not** required
- Use transfer discharge status code 65 (psych transfer) (**Note:** use this code for either transfer to a BH unit within the same facility or transfer to a separate BH facility)
- Ancillary services related to the medical portion of the stay should be included on the claim

BH Claim
- Submit Bill Type 11X
- Submit revenue code 0160 (Other Room & Board) (units should be submitted in days)
- Ancillary services related to BH services should be included on the claim for boarding services
- If the member is ultimately transferred to a BH facility, use discharge status code 65 (psych transfer)

COMPENSATION/REIMBURSEMENT INFORMATION

Compensation for inpatient treatment and related services is based on the applicable network contracted rate (e.g., diagnosis-related group [DRG]). Refer to your current contract for details regarding inpatient reimbursement provisions. The inpatient reimbursement rate is inclusive of all services supplied by the facility, including, but not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Diagnostic services
- Medication and supplies
- Nursing care
- Preadmission testing
- Operating room services
- Radiology/Imaging
- Recovery room services
- Therapeutic items (drugs and biologicals)

If a member receives multiple levels of service within the same episode of care, compensation for the lower-intensity services will be bundled into the payment for the highest intensity services rendered:

1. Hospital inpatient services
2. Hospital surgical day care services
3. Hospital ambulatory/minor surgical services
4. Hospital observation bed services
5. Hospital emergency department (ED) services
6. Hospital urgent care clinic services
7. Hospital clinic services

Preadmission Testing
Tufts Health Plan does not separately compensate routine preadmission testing performed prior to an admission. The following procedure codes will be included as part of in the inpatient compensation (**Note:** this list is not all-inclusive):

Code	Description
71020	Radiologic examination, chest, two views, frontal and lateral
80051	Electrolyte panel
80053	Comprehensive metabolic panel
82565	Creatinine; blood
84520	Urea nitrogen; quantitative
86900, 86901	Blood typing; ABO, Rh (D)

Code	Description
85004	Blood count; automated differential WBC count
85014	Hematocrit (Hct)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Tracing only, without interpretation and report
93010	Interpretation and report only

Acute Admissions that Do Not Meet Inpatient Level of Payment

Tufts Health Plan will consult with facility care managers on level of payment decisions when reviewing admissions concurrently. Tufts Health Plan reserves the right to review admissions retrospectively. Claims for acute admissions will be denied if it is determined that the services provided did not meet criteria for inpatient level of payment. The hospital's care management department will be notified, and the hospital may bill for outpatient services provided.

Administratively Necessary Day (AND)

Authorized AND are compensated in accordance with the provider's health services agreement and/or MassHealth regulations, when applicable.

Bedside Nursing Services

Tufts Health Plan does not separately cover bedside nursing services or procedures performed during the inpatient stay as part of the room and board. These services are subsumed under the inpatient compensation paid to the facility.

Lack of Information

Tufts Health Plan will deny payment of claims when the facility fails to provide requested clinical information within 24 hours of the request.

Facilities with DRG Arrangements

The following compensation and reimbursement information applies to facilities with a DRG payment arrangement with Tufts Health Plan.

All Patient Refined (APR) DRGs 9550 and 9560

Tufts Health Plan will deny claims assigned to either APR-DRGs 9550 or 9560. Corrected claims may be submitted in accordance with Tufts Health Plan's timely filing limits outlined in the Claims Requirements, Coordination of Benefits, and Dispute Guidelines chapter of the Tufts Health Public Plans Provider Manual.

Eligibility Changes During an Inpatient Admission

For hospitals compensated using the APR methodology, if an inpatient admission occurs prior to a member's effective date or if a member terminates while receiving inpatient services, Tufts Health Plan will prorate the per diem rate based on the member's eligibility. Tufts Health Plan pays the lesser of the per diem rate which will not exceed the APR-DRG allowed amount.

Tufts Health Direct

Tufts Health Plan only compensates for the portion of the member's stay during which they were enrolled as a member.

Tufts Health Together

Tufts Health Plan only compensates for the portion of the member's stay during which they were enrolled as a member.

Tufts Health Plan will compensate hospitals for inpatient services utilizing the Massachusetts Executive Office of Health and Human Services (EOHHS) APAD compensation methodology. The compensation is a hospital-specific, all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge using the APR-DRG and Severity of Illness (SOI). Tufts Health Plan will use EOHHS APR-DRG assigned weights. The admission date determines all inpatient compensation terms.

Tufts Health RITogether
Tufts Health Plan only compensates for the portion of the member's stay during which they were enrolled as a member.

Tufts Health Plan will compensate hospitals for inpatient services utilizing the Rhode Island Executive Office of Health and Human Services (EOHHS) compensation methodology. The compensation is a hospital-specific, all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge using the All Patient Refined-Diagnosis Related Group (APR-DRG) and Severity of Illness (SOI). Tufts Health Plan will use EOHHS APR-DRG assigned weights. The admission date determines all inpatient compensation terms.

Tufts Health Unify
Compensation is determined by the member's enrollment status at the time of acute hospital admission. If the member is enrolled in Tufts Health Unify on acute hospital admission, Tufts Health Plan compensates for the entirety of the member's stay through discharge, even if the member disenrolled prior to discharge.

Tufts Health Plan currently uses the Medicare MS-DRG as established by CMS to assign an MS-DRG to an inpatient claim. Refer to the CMS website for additional information.

Note: If a member terminates with Tufts Health Plan while receiving acute hospital inpatient services, Tufts Health Plan is responsible for the entire acute hospital admission until the patient is discharged.

Transfers of Care
If a member is transferred to another acute facility for continued acute inpatient care, Tufts Health Plan will compensate the transferring hospital at a per diem rate that will not exceed the case APR-DRG rate including any applicable outliers. (**Note:** Tufts Health Plan does **not** cover out-of-network acute facilities without prior authorization)

Facilities with Non-DRG Arrangements
The following compensation and reimbursement information applies to facilities with a non-DRG payment arrangement with Tufts Health Plan.

Bedside Nursing Services
Tufts Health Plan does not separately cover bedside nursing services or procedures performed during the inpatient stay as part of the room and board. These services are subsumed under the inpatient compensation paid to the facility.

Delay Days
Tufts Health Plan does not compensate providers for delay days. A delay day is a day that a member spends in a facility waiting for medically necessary diagnostic testing, treatments, therapies (including physical therapy), consultations, surgical/other procedures, or test results. The delay may be due to facility scheduling or staffing issues, which represent an interruption in evaluation or treatment and therefore result in a longer length of stay than if the care had been efficiently provided and/or arranged. Regardless of whether the day meets medical necessity criteria, such days will not be paid. The decision may result in a denial of payment to the hospital, physician, or both.

Transfers of Care
If a member is transferred to another acute facility, the facility will be compensated in accordance with their health services agreement. (**Note:** Tufts Health Plan does **not** cover out-of-network acute facilities without prior authorization)

Tufts Health Direct, Tufts Health Together, Tufts Health RITogether
Tufts Health Plan only compensates for the portion of the member's stay during which they were enrolled as a member.

Tufts Health Unify
Compensation is determined by the member's enrollment status at the time of admission. If the member is enrolled in Tufts Health Unify on admission, Tufts Health Plan compensates for the entirety of the member's stay through discharge, even if the member disenrolled prior to discharge.

Note: If a member terminates with Tufts Health Plan while receiving inpatient services, Tufts Health Plan is responsible for the entire admission until the patient is discharged.

ADDITIONAL RESOURCES

- Emergency Department Services Payment Policy
- Inpatient and Intermediate/Divisionary Behavioral Health (Mental Health & Substance Use Disorder) Facility Payment Policy
- Inpatient Rehabilitation and Long-Term Acute Care Facility Payment Policy
- Observation Services Payment Policy
- Obstetrics/Gynecology Professional Payment Policy
- Newborn Payment Policy
- Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy
- Skilled Nursing Facility Payment Policy

DOCUMENT HISTORY

- July 2023: Clarified case rate inclusion in 30-day readmission time frame, effective for DOS on or after September 1, 2023; clarified late charges billing requirements
- February 2023: Annual code updates; moved preadmission testing code table previously located in the Outpatient Facility Payment Policy
- October 2022: Annual policy review; added information for ED boarding services provided during inpatient acute medical admissions for Tufts Health Direct members, effective for DOS on or after November 1, 2022
- July 2022: Updated readmission time frame from 14 to 30 days for acute medical admissions for Tufts Health Direct, Tufts Health Together, and Tufts Health RITogether, effective for DOS on or after September 1, 2022
- May 2022: Added existing hospital hierarchy compensation information
- August 2021: added AND services billing instructions for Tufts Health Direct, Tufts Health RITogether and Tufts Health Unify members, effective for DOS on or after October 1, 2021
- January 2021: Reviewed by committee; combined DRG and non-DRG payment policies; added definition of DRG and joint surgery program prior authorization requirements, removed inpatient notification submission channels and referred to the Tufts Health Public Plans Provider Manual; removed language for "never events," and linked to the Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy in Additional Resources
- November 2020: Added condition code 40 billing requirement for Tufts Health Unify members being transferred to another facility, in accordance with CMS requirements
- July 2020: Updated general benefit information and billing instructions boiler plate language
- October 2019: Newborn information removed; reviewed by committee
- February 2019: Removed link to retired payment policy (Timely Filing of Claims Policy)
- November 2018: Added APR DRGs 9550 and 95560 claim information effective January 1, 2019; added Inpatient Notification Form to the submission channels information
- August 2018: Policy created

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the requirements stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan's audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements when applicable, adherence to plan policies and procedures and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products as identified in the checkboxes on the first page. It is incorporated by reference into the Tufts Health Public Plans Provider Manual. Payment is based on member benefits and eligibility; medical necessity review, where applicable; and your provider agreement. Adherence to these requirements by a provider does not guarantee payment. Tufts Health Plan reserves the right to amend a payment policy at its discretion.